Development of an empathic stance

Dialogical sequence analysis (DSA) of a single case during clinical child neurological assessment procedures

SOILE TIKKANEN

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ABSTRACT: DEVELOPMENT OF AN EMPATHIC STANCE – DIALOGICAL SEQUENCE ANALYSIS (DSA) OF A SINGLE CASE DURING CHILD NEUROLOGICAL ASSESSMENT PROCEDURES

The focus of this research was the child neurological assessment as parent's process of change. The case material of the research consisted of video-recorded and transcribed encounters between the parents and staff at the paediatric neurological outpatient clinic during the assessment of a 4-year-old girl who was referred to the child neurological team due to contact and communication problems. The dialogues between the parent and the professionals were analysed through dialogical sequence analysis (DSA), which is a conceptual tool and method for examining dialogical patterns in utterances. The interactive pattern between the parent and the child, which started to manifest during the initial assessment process and the first session, was formulated by DSA. Development of the parent's observing stance on the problematic pattern was traced using the assimilation model, which illustrates therapeutic change and qualitative changes in the initial situation as a sequence of eight consecutive stages.

The central finding of the first sub-study is that the child neurological assessment has therapeutic implications for the parent. What in the initial stage was perceived solely as the child's behavioural problem was gradually formulated into an interactive pattern between *controlling/coercive–adaptive or controlling/coercive–rebellious/resisting*. As the assessment proceeded, the parent's own role in the pattern was brought into empathic observation and as the object of self-reflection. The parent's sense of otherness in relation to the child also developed. During the course of a three-month follow-up, the parents had developed new methods of interacting with the child and controlling their own behaviour in conflict situations. The parents perceived the child as an individual actor and not solely as someone who is defined through the parent's position.

The results of the first theory-based case study suggest that the development of a reflective, empathic relationship with oneself precedes the formation of an empathic relationship with another person.

The second theory-based case study (of the same case) illustrates the changes in the parent's positioning and the parent forming an empathic relationship with herself and with the other

during a short episode in the course of a single session. The second sub-study illustrates the stages during which the parent's position changed from her own perspective into acknowledging the child's perspective and gaining a sense of otherness in relation to the child. This process was mediated by the observer position which enabled perceiving the whole interaction pattern, in which the parent participated and in which her actions affected both herself and the other party.

The third sub-study focuses on the same case as the two previous sub-studies. It illustrates how the problematic interaction pattern was manifested as a conflict during a network meeting between the parents and the preschool staff, which took place at the end of the child's assessment process. The conflict was resolved by the neuropsychologist formulating the situation as a problematic pattern and from the perspective of the child. The stages of conflict resolution and the development of an empathic stance were analysed and illustrated through DSA.

The child neurological assessment process can be a therapeutic intervention for the parent. The micro-analytical method of dialogical sequence analysis, combined with the assimilation model, proved to be applicable when examining individual results within child care and assessment processes. The research shows that dialogical sequence analysis can also be applied while examining interaction within group situations.

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TIIVISTELMÄ: EMPAATTISEN NÄKÖKULMAN MUOTOUTUMINEN– TAPAUSTUTKIMUS LASTENNEUROLOGISESTA TUTKIMUSPROSESSISTA DIALOGISTA SEKVENSSIANALYYSIA (DSA) KÄYTTÄEN

Tässä tutkimuksessa tarkasteltiin lastenneurologista tutkimusprosessia kehittymistapahtumana vanhemman kannalta. Tutkimuksen tapausaineisto koostui videolle nauhoitetuista ja litteroiduista vanhemman ja työntekijöiden keskusteluista 4-vuotiaan puheen ja kontaktiongelmien vuoksi tutkimuksiin lähetetyn lapsen moniammatillisessa tutkimusprosessissa lastenneurologian poliklinikalla. Vuorovaikutusasetelmia vanhemman ja työntekijän ilmaisusta hahmotettiin dialogisen sekvenssianalyysin (DSA) avulla, joka on käsitteellinen jäsennysväline ja menetelmä ilmaisussa näyttäytyvien dialogisten asetelmien tutkimiseksi. Tutkimusprosessin alkutilanteessa ja ensimmäisellä käynnillä hahmottuva vanhemman ja lapsen välinen vuorovaikutusasetelma formuloitiin DSA:lla. Kehittymisen vaiheita vanhemman ongelmallisen asetelman havainnoinnissa tarkasteltiin assimilaatiomallin avulla, joka kuvaa terapeuttista muutosta ja alkutilanteen laadullisia muuntumia kahdeksana peräkkäisenä vaiheena.

Ensimmäisen osatutkimuksen keskeinen tulos on, että lastenneurologisella tutkimusprosessissa on terapeuttisia vaikutuksia vanhemman kannalta. Alkutilanteessa vain lapsen käyttäytymisongelmana hahmottunut jäsentyi vähitellen vanhemman ja lapsen välisenä vuorovaikutusasetelmana *kontrolloi/pakottaa – mukautuu tai kapinoi/vastustaa*. Tutkimusprosessin kuluessa vanhemman oma osuus asetelmassa tuli empaattiseen tarkasteluun, ja itsehavainnoinnin kohteeksi. Myös vanhemman toiseuden taju suhteessa lapseen kehittyi. Seurannassa 3 kk kuluttua vanhemmille oli kehittynyt uusia keinoja toimia lapsen kanssa ja myös oman toimintansa hillintään konfliktitilanteissa. Lapsi hahmottui vanhemmalle erillisenä toimijana eikä ainoastaan vanhemman asemoitumisesta käsin määrittyvänä. Ensimmäisen teoreettisen tapaustutkimuksen tulokset antavat näyttävät, että reflektiivisen, empaattisen suhteen muodostuminen itseen edeltää empaattisen suhteen muodostumista toiseen.

Toinen teoreettinen tapaustutkimus kuvaa vanhemman asemoitumisen muutoksia ja empaattisen suhteen muodostumista itseen ja toiseen yhden käynnin kuluessa lyhyen episodin aikana samassa tapauksessa. Toinen osatutkimus havainnollistaa ne vaiheet, joiden kautta vanhemman näkökulman muutos äidin omasta näkökulmasta lapsen näkökulman huomioimiseen ja toiseuden tajuun suhteessa lapseen eteni sellaisen havaitsijaposition välittämänä, josta käsin

voi tarkastella koko vuorovaikutusasetelmaa, jossa on osallisena sekä oman toiminnan seurauksia itselle ja toiselle.

Kolmas osatutkimus kuvaa ongelmallisen vuorovaikutusasetelman näyttämöllistymisen konfliktina saman lapsen tutkimusprosessin loppupuolelle sijoittuneessa päiväkotineuvottelussa sekä sen laukeamisen sen seurauksena, että työntekijä muotoili meneillään olevan tilanteen ongelmallisen asetelman kaltaisena ja Sadun näkökulmasta. Neuvottelussa syntyneen konfliktin ratkeamisen ja empaattisen näkökulman rakentumisen vaiheet analysoitiin ja kuvattiin DSA:lla jäsennettyä alkuformulaatiota käyttäen.

Lastenneurologinen tutkimusprosessi voi olla terapeuttinen interventio vanhemman kannalta. Tutkimuksessa assimilaatiomallin kanssa käytetty mikroanalyyttinen menetelmä, dialoginen sekvenssianalyysi, osoittautui käyttökelpoiseksi lasten hoito- ja tutkimusprosessien yksilöllisen tuloksellisuuden tarkastelussa. Tutkimus osoittaa, että dialoginen sekvenssianalyysi toimii myös ryhmätilanteiden meneillään olevan vuorovaikutuksen tarkastelussa.

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I started my doctoral studies in the Department of Psychology at the University of Joensuu. Later the personnel of the School of Educational Sciences and Psychology at the University of

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Hospital District of Helsinki and Uusimaa Ethics Committee for Paediatrics, Adolescent Medicine and Psychiatry gave the ethical approval to my initial research plan in 2005. I express my respectful gratitude to HUCH, Jorvi Hospital for granting the research permission for this project and to Docent Hannu Heiskala for being the doctor in charge in this research project.
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Numerous people have influenced greatly through discussions and conversations on different occasions during the process of preparing this thesis and even before it. I could never have imagined that the discussions on the basis Mikael's handouts and papers on DSA and Bakhtin during the 1996-2000 advanced level Cognitive Analytic Therapy psychotherapist course and its supervision sessions could have led to this: that I am using DSA as a research method in this study. I am grateful to my CAT colleagues from this course, Ari Lahtinen, Tarja Hämäläinen, Aulikki Reino, Sirpa Tevilä, Raimo Koivula and Maire Riipinen for these discussions.

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Helsinki, March 2015 Soile Tikkanen

Original publications

This thesis is based on the following original studies, referred to in the text by the Roman numerals I-III:

I Tikkanen, S., Stiles, W. B., & M. Leiman (2011). Parent development in clinical child neurological assessment process: Encounters with the assimilation model. *Psychotherapy Research*, *21*, 593-607.

II Tikkanen,S., Stiles, W. B., & Leiman, M. (2013). Achieving an empathic stance – Dialogical sequence analysis of a change episode. *Psychotherapy Research 23*, 178-189.

III Tikkanen, S. & Leiman, M. (2014). Resolution of an impasse at a network meeting – Dialogical sequence analysis of the use of a shared formulation**.** *Counselling Psychology Quarterly*, *27*, 154-173.

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APPENDICE

1 Introduction

"Every case has something to teach, though investigators typically don't know what they will learn when they begin to study it."

(Stiles & Brinegar, 2007, p. 115)

The objective of the assessment process of a child is to form a comprehensive picture of the child's situation in order to relieve or solve the problems that are the reason for seeking help. The assessment process also seeks to promote change for the parent which has a positive effect in relation to the child.

The aim of *outcome research* on the child assessment is to find out whether *changes* that promote the development of the child actually *take place* during the assessment in the child's everyday life, in interaction relationships and activities with parents and other family members, in day care and school, and in rehabilitative and medical care. For the parent, the change can involve, for example, observing the child's or their own actions from another perspective, and finding new methods of interacting with the child. The challenge of evaluating the outcome of the treatment and assessment procedures lies in capturing and illustrating the interaction phenomena and their variations between the assessing team, the parent and the child, and also parental change process while also taking the special characteristics of the individual cases into account. This requires a *process research* approach (Dahl & Kächele, 1988; Frommer & Rennie, 2001; Hill & Lambert, 2004; Lepper & Riding, 2006; Stiles & Angus, 2001; Stiles, Shapiro, Harper, & Morrison, 1995; Strupp, Schacht, & Henry, 1988; Toukmanian & Rennie, 1992), in other words, concentrating on *how* a possible change takes place during the assessment and what the consequences of the change are. The study of change can be focused in several ways. The focus of this thesis is the therapeutic change that takes place in the parent during the course of the child neurological assessment process.

In the following sections, I will go through the stages through which the subject matter of the thesis and its three sub-studies have evolved and how the research questions were formulated and developed further during the research process. The research topic became more focused and the research questions found their final form as a result of a dialogue between thoughts and questions raised by clinical work performed before the research process, the scientific literature, empirical material gathered for the research, and the theories and methods applied in the analysis of the material. In contrast to standard quantitative research, the research questions were not formulated in advance or based on an existing theory (McLeod, 2007, 2010). During the research process, observations on the special nature of the material and the phenomena occurring in the material have moulded my selection of the research subject for the following sub-study. In addi-

tion, the methods and theories used to analyse the material have played a significant role in selecting the final and central research questions.

This research is based on questions that have arisen in the course of my professional history: from my participation in clinical child neurological assessment processes as a member of a multi-professional team, and my work as a neuropsychologist at the child neurology outpatient clinic for specialist medical care since 1992. In the tradition of qualitative research it is common that the researcher personally takes part in the process being observed and studied (McLeod, 2007, 2010). I am familiar with the context of my research, the child neurological assessment process, as well as the case that is studied as the research subject. As the neuropsychologist of a multi-professional team, I participated in the child neurological assessment for the case studied in this research. I will begin by briefly describing the nature and objectives of the clinical assessment that is conducted at the child neurology outpatient clinic.

1.1 THE CHILD NEUROLOGICAL ASSESSMENT PROCESS AS RESEARCH CONTEXT

The basic task of the child neurology outpatient clinic is to canvass, treat and rehabilitate possible neurological disorders or diseases that may cause the developmental problems of the child. Child neurological assessment within specialist medical care always involves a referral from primary health care or a private practitioner (Herrgård & Renko, 2000). If the case involves further assessment of the developmental status of a preschool-aged child, it is usually conducted as a multi-professional collaboration at the child neurology outpatient clinic (Larsson, 2009; Sillanpää, Airaksinen, Iivanainen, Koivikko, & Saukkonen, 1996). The child neurological team usually comprises a child neurologist, a social worker, a speech pathologist, a physiotherapist, an occupational therapist, a neurological nurse and a neuropsychologist.

The objective of diagnosing the child's developmental problems and difficulties is to reach a new understanding of the child's situation and their developmental issues, as well as to find, on the basis of the evaluation of the situation, means to support the child's development in their everyday life (at home, at day care or school) and a suitable rehabilitation programme, e.g. for compensating for difficulties or exercising skills.

In practice, child neurological assessment begins by carefully mapping preliminary information and the child's situation. Information about the child is gathered from the parent and, with their permission, also from day care/preschool. The child neurological assessment proceeds with examinations performed by different professionals, possible blood tests and other medical examinations. After the assessment, the findings and the diagnosis made by the professionals are discussed with the parents. The child's treatment and rehabilitation programme is then planned taking these findings and observations into account. A meeting between the professionals and the parents regarding the child's rehabilitation plan may also take place (Sillanpää, Airaksinen, Iivanainen, Koivikko, & Saukkonen, 1996).

In the clinical child neurological assessment, the focus is on the child and their developmental issues. The parents participate in the assessment process as collaborative partners and experts on the child (Ferguson & Ferguson, 1987).

1.2 FORMULATING THE PARENT'S PERSPECTIVE AS THE SUBJECT OF STUDY

The starting point of this research project was to observe and highlight in particular the parent's perspective and participation in the child neurological assessment and their role in utilising and applying the assessment findings regarding their child. This is also reflected in the title I gave to the project, *Concern over development and the formation of the parent's perspective – The perspective of a parent bringing their child for examination due to developmental problems and the perspective's formation in a dialogue with the professionals working with the child* (original title in Finnish: *Huoli kehityksestä ja vanhemman näkökulman muotoutuminen - Kehitysongelmien vuoksi lastaan tutkimuksiin tuovan vanhemman näkökulma lapsensa tilanteeseen ja sen muotoutuminen dialogissa lasta tutkivien työntekijöiden kanssa*). In the planning stage of the study, the research questions primarily dealt with the parent's role in the assessment process. Even though the perspective of the parent has always been the leading focus of the study, when I was formulating the title, I had not grasped that my study would ultimately also focus on the outcome of the child neurological assessment and the prerequisites for good results.

Literature on care and assessment processes for children has outlined these processes as arenas where the parents' and professionals' differing viewpoints may encounter one another and be negotiated, among other matters (Abrams & Goodman, 1998; Alasuutari, 2003; Gill & Maynard, 1995). Within the field early childhood education, the theme has been discussed through the concepts of *parental participation* and *educational partnership* (Foot, Howe, Cheyne, Terras, & Rattray, 2002; Hamilton, Roach & Riley, 2003; Karila, 2003, 2005, 2006; Kekkonen, 2012). I studied and compared the differing viewpoints of parents and professionals in the context of the child neurological assessment in my licentiate's thesis. The work was published in the publication series A 01:2004 of Jorvi Hospital with the title *Eloisat viipparit – Lastenneurologisella poliklinikalla tutkittujen 5- ja 6-vuotiaiden lasten psyykkiset oireet vanhempien ja päiväkodin kuvaamina* ('Lively rascals –Psychiatric symptoms of five- and six-year-olds treated at the child neurology outpatient clinic, as described by the parents and day care centres') (Tikkanen, 2004). In the study, I made a cross-section comparison of the parents' and day care centres' descriptions of children's psychiatric symptoms, social skills, attentiveness and self-confidence problems within various developmental issues detectable in child neurological assessment (such as communication problems, concentration difficulties), etc. The descriptions were gathered through questionnaires.

The research design of the comparison of the parents' and professionals' viewpoints was static in its approach. In the current research, I preferred to study the parent's perspective while it was modified and reshaped in dialogue with the assessment process. During clinical work, the question that parents so often posed to the professionals after the assessment resonated with me in a special way: "Tell us what we can do." From the viewpoint of the outcome of the clinical assessment work, it is relevant to ask: how do the professionals' observations and assessment findings meet the parents' wish to do something and change their own behaviour in relation their child? And, on the other hand: In what way(s) do the parents change, or do they stay with their initial understanding of and attitude towards the child's situation during and after the assessment period?

While I was planning the research project, I wrote in my work diary on 16 August 2004: *"What I am pondering upon in particular is how the parents retain their perspective: how do they, in the normative hospital environment and mode of communication, retain their image of their child, and if there is a detectable change, during which stage does it occur? On the other hand: how does the [parent's] speech reflect their way of being with the child? How does the parent understand their child and act in concrete situations?"*

Methods of discursive psychology and conversation analysis seem to have directed the formulation of my thoughts on how to study the encounters of parents and professionals as negotiations of reciprocal positioning (Alasuutari, 2003; Mischler, 1984; Potter & Wetherell, 1987) and as the conversation practices or ways of speech through which institutional tasks are constructed during these encounters (Abrams & Goodman, 1998; Frankel, 1984; Lundan, 2009; Maynard, 1991; Peräkylä, 1997, 1998a,1998b, Quine & Rutter, 1994; Schegloff & Sacks, 1973; Suoninen & Lundan, 2006). However, these theoretical approaches and methods for studying the encounters between parents and professionals did not offer sufficient tools for outlining the change in the parent's perspective.

During the planning stage of the research I also considered whether I could find conceptual tools from *psychodynamic crisis theory* (Cullberg, 1973, 2006) for formulating the subject of research. The theory has been applied as a background theory rather widely, particularly within research on parents' reactions when receiving primary information on their child's disability (Hänninen, 2004; Irvin, Kennell, & Klaus, 1976; Kalland, 1995). A crisis is, in its nature, an unexpected event beyond one's own control (Cullberg, 2006). It is a form of negative surprise that generates insecurity and disrupts routines (Hänninen, 2004). On the basis of crisis theory, the parent's process has been described as adaptation to the event.

Irvin et al. (1976) have outlined the stages of the crisis that the birth of a disabled child awakes in the parents as follows: The immediate information comes as an immense shock. The *shock stage* is followed by the parents' *stage of disbelief and denial*. After the *stages of grief, anger, anxiety and hesitation*, the parents begin to *reach balance*, and the gradual process of adapting to the situation begins, and may last a long time. In the *stage of reorganisation*, the parents begin to manage the responsibilities and actions that the child's situation requires. Hänninen (2004) has mapped the experiences of encounters between parents and hospital personnel in the context of immediate information related to the new-born child. He has used the anthropological concept of *liminality* (Turner, 2007) to describe the *intermediate space of doubt* or *time of uncertainty*, where the stricken parents are situated in regard to their child's possible disability (Hänninen, 2004). Doubt diminishes as information increases, but the constant fluctuation of emotion goes on until the doubt is completely dissolved (Hänninen, 2004).

Even though the concept of liminality may reflect generally, from the clinical point of view, the parent's situation, the formulations of psychological crisis theory felt inadequate in regard to my research objectives. Crisis theory only focuses on the parent's process of adaptation, and does thus not provide any tools for studying the interaction between parent and child. After all, I had from the very beginning set the objective of discovering whether the parent's perspective on this interaction changed during the child neurological assessment process and what contributed to it.

Consequently, I adopted the *parent's observer position* as a concept for capturing the parent's perspective in the first research plan for the project: (30 March 2005): *"The parent's viewpoint, a specific observer position in relation to the child, includes not only the parent's observation of the child as an independent actor, but also the parent's role when interacting with the child. The parent's observer position becomes visible, develops and changes its form in dialogue when acting with the child and, on the other hand, in dialogue with other adults that act with the child, with different educational professionals and also with those assessing the child."*

When adopting the observer position, the parent establishes a positioned relationship with, or an active stance to, the objects of observation, i.e., both to the child and their actions, as well as to the parent's own actions with the child. According to the above description, the parent's observation is positioned activity that constantly changes and takes new forms during various interactions.

I selected the concept of the parent's observer position partly due to my background as a psychotherapist. In cognitive analytic psychotherapy (CAT), the individual's developing self-reflection is described using the concept of the *observing eye* (Leiman, 1994, 2012; Ryle & Kerr, 2002). This concept describes the gradually emerging 'place' from where the clients can begin to observe their own actions. In cognitive analytic psychotherapy, the clients aim to develop, with the help of the therapist, an observing stance to reoccurring problematic action patterns and situations. In CAT the patient/client aims to develop, with the help of the therapist, the observing eye in relation to reoccurring problematic methods of action and situations by describing the material produced by the patient/client in an empathic yet neutral manner; the therapist and patient/client thus seek to find a shared method of observation (Leiman, 1994; Ryle, 1992, 1997; Ryle & Kerr, 2002;).

1.3 RESEARCH QUESTIONS

Based on these preliminary ponderings the research questions of this thesis can be formulated at the beginning of the first study in the following way:

1. What is the contribution of a multi-professional child neurological assessment, which did not explicitly aim at therapeutic change, to parent development?
2. Can changes in the parent's perception of and interaction with the child be seen across the assessment sequence, and how can they be described?

2 Methods – how to study the parent's observer position?

These initial formulations of the study subject became concrete when my thesis supervisor, Professor Mikael Leiman, suggested that I gather case material by video recording discussions between the parents and professionals during the child neurological assessment process.

2.1 CASES IN THE RESEARCH MATERIAL

The encounters between parents and professionals during the child neurological assessment may, according to the clinical practice, involve preliminary interviews by the various professionals, feedback sessions with one or several professionals involved in the assessment, or discussions with rehabilitation staff or other members of the child's network. The hospital's practice is that the child neurologist who has read the referral drafts the first plan for the examinations and their order.

During the preliminary interview, the child's background and different aspects of their development are mapped. The interview usually proceeds via the professionals asking questions and the parents describing their observations on their child and the child's situation as well as their own concerns, etc. During the feedback sessions, the professional(s) report their findings, and their impact in regard to the child's everyday life is discussed with the parents. The parents, the professionals who have assessed the child and the adults who provide care to and rehabilitate the child in day care may also attend the network meetings.

Since the research question focuses on the parent's perspective, discussions between parents and professionals during the assessment comprised the primary research material. The case material recorded from the interviews and feedback sessions consists of the utterances of the parents, the child and the professionals. Through their utterances, the parents convey in the conversation their own conceptions, feelings and thoughts, their present understanding of their problems or their child's problems and what they wish to achieve in collaboration with the professional and the child neurological team, their attitude towards their child and the on-going assessment process, etc.

The starting point for gathering the material was that the parent's perspective – the parent's observer position – is conveyed through their utterances that contain their attitude and position in relation to observed objects (e.g. the child's development, actions and behaviour or the parent's actions with the child, the problems they are experiencing with the child, etc.). In their utterances, the parents position themselves in relation to and take a stance towards the matters discussed, i.e. the objects of observation (Leiman, 2012). The professionals also set the tune for

the parent's utterances with their questions or respond to them, and guide or broaden the ongoing observation into new directions and new areas, new subjects.

The gathering of the material could begin after the positive statement on the ethical viewpoints of my research plan by the Hospital District of Helsinki and Uusimaa Ethics Committee for Paediatrics, Adolescent Medicine and Psychiatry (Dnr 33/E7/200) was followed by Jorvi Hospital granting research permission. The research followed the procedure of receiving *informed consent* from the parents in regard to the research, as required by the ethical principles of research. As the children involved in the study were aged 3 years and 4 months to 5 years and 1 month, their consent was not required. The material was gathered at the child neurology outpatient clinic at Helsinki University Central Hospital (HUCH) Jorvi Hospital between May 2005 and March 2006.

The preliminary interviews, feedback sessions and other discussion between the professional and the parents were recorded during the clinical child neurological assessments and follow-ups (according to schedule or 3–6 months after the assessment) of 7 children in total (3 girls, 4 boys). The actual assessment sessions between the children and the professionals (neurologist, neuropsychologist, speech pathologist) were not recorded, since the presence of a camera was noted to disturb the children's ability to concentrate on the ongoing assessment.

In the research material the assessment periods were initiated with a preliminary interview between the neuropsychologist and the family, the neuropsychologist's assessment and a feedback session with the parents regarding the findings. This was followed by the preliminary interview with the speech pathologist and her assessment and feedback sessions, parent –child interaction assessment and the related feedback, preliminary interview with the neurologist, neurological examination of the child and lab tests, a possible EEG test, a telephone appointment with the neurologist or a letter regarding these findings sent to the family. The assessment period concluded with a day care or network meeting, in which one or both of the special professionals that were involved in the assessment (neuropsychologist, speech pathologist) participated. In addition, a follow-up meeting was scheduled three months after the assessment period.

The assessment periods of each case in the research material comprised on average of 11 separate visits to the outpatient clinic, including the interaction assessments and their feedback sessions, the day care meeting and the follow-up meeting. The assessments for the families who had given their consent were fairly similar and also reflected normal clinical practice.

The amount of recorded material for the assessment processes of the seven children was approximately 39 hours in total. The video tapes were digitised into MP3 format at the Jorvi Hospital video centre. The tapes of the assessment of three children (Satu, Ville and Erja, pseudonyms) were transcribed in the early stage of analysis. The transcription follows the Mergenthaler & Stinson (1992) transcription standard commonly used in psychotherapy research. The analysis of the tapes of these three children produced a total of 420 pages of transcribed material.

2.1 SELECTING THE STUDY CASE

The first stage of qualitative analysis was conducted while listening to, watching and transcribing the recorded material. The question of how to study the parent's observer position and their

positioning in this multi-case case material remained unresolved. Should I study the parent's observer position *as a phenomenon* (McLeod, 2007, pp. 3–4), in which case the whole study would focus on how the different cases reflect this phenomenon, studying its crucial features, average occurrence or variation between different cases – in other words, adopting an *inter-individual* approach (Eells, 2007a; Lewin, 1931)? Or should I study *one individual case* as it were (McLeod, 2007)? In studying a single case, the research could centre around describing the case's clinical special features, which would represent valuable case documentation and would convey its richness to the readers of the research (McLeod, 2007). Alternatively, the case could focus on studying the phenomenon, the parent's observer position, during its development and as a process within the context of a single case (Eells, 2007a, 2009; Lewin, 1931; Vygotsky, 1978; Zinchenko, 1985).

Based on the recorded and transcribed case material, I ended up selecting a single case and intensively studying the development occurring within it (SSR, single subject research, Eells, 2007a) on the basis of the so-called developmental paradigm (Leiman, 2006; Stiles, Meshot, Anderson, & Sloan, 1992). In this approach, the research focuses on an individual case, its special features in specific concrete situations, its intra-individual development and the change and adaptation occurring within it (Eells, 2007a; Lewin, 1931; Stiles et al. 1990, 1992; Strupp et al., 1988). From the gathered case material, the case of Satu (pseudonym) stood out due to its special feature, the problematic parent–child interaction which manifested itself as early as during the first visit.

Therefore, I chose to study the parent's observer position and its development in Satu's case. Satu's assessment was selected particularly because in her case, the neuropsychological symptoms and the problematic interaction pattern between child and parent seemed to be intertwined (Beitchman, Nair, Clegg, Ferguson, & Patel, 1986; Cantwell & Baker, 1987; Conti-Ramsden & Dykins, 1991; McDade, 1981).

The problematic parent–child interaction that manifested itself during the first visit of Satu's assessment, the preliminary interview by the neuropsychologist, caught my attention even during the first stage of analysis. Satu refused and objected strongly, turning her back on both her parents' and the professionals' suggestions. The parents, and especially the mother, responded with strict control and coercion, which further emphasised Satu's defiant behaviour and objection. During the neuropsychologist's preliminary interview, the parents also described Satu's rebellious behaviour at home as well as the methods (the 'yelling corner', among others) that they used with her. The problematic interaction pattern and its manifestation during the various visits during the course of the assessment, from the preliminary interview to the three-month follow-up, could be followed in the transcribed material.

In the following sections, I will describe Satu's case in more detail, and the stages of her child neurological assessment and the central findings. I will subsequently describe the methodological tools with which I analysed the recordings and their transcriptions from Satu's neuropsychological assessment.

2.2 CASE SATU

Satu, aged 4 years 9 months, was the only child of Finnish-speaking parents. She came for child neurological assessment with a referral from a health care centre doctor by the recommendation of the speech pathologist. The referral requested further examinations regarding speech development, understanding and making and maintaining contact, "in order to outline which developmental sections need to and can be supported, and how". The referral noted issues that had arisen during child health monitoring, early development, family history and early stages in day care, as well as the local speech pathologist's assessment findings and observations, and a recommendation for further investigation. The referral came with the following appendices: the speech pathologist's statement, the day care centre's statement and the growth curves from child health monitoring.

The child neurologist of the outpatient clinic planned the multi-professional child neurological team assessment for Satu based on the description in the referral. The team assessing Satu included a child neurologist, a speech pathologist and a neuropsychologist. The EEG test and the follow-up meeting with the neuropsychologist were postponed until observations had been made during the assessment process. The parents brought Satu to the examinations and participated in the preliminary interviews and feedback sessions with the different professionals, the network meeting and the 3 month follow-up session.

Satu's assessment is described in Table 1. Time is expressed in days since the beginning of the assessment. Table 1 also shows which sessions were recorded and who were present in these sessions.

Table 1: Satu's assessment process

Time	Number and content of session	Session members	Video
1st day	1. Neuropsychological assessment interview	mother, father, Satu neuropsychologist	Yes
1st day	2. Neuropsychological assessment (1st part)	Satu, neuropsychologist	No
2nd day	3. Marschak Interaction Method (MIM) with mother	Satu, mother	Yes
2nd day	4. Neuropsychological assessment (2nd part)	Satu, neuropsychologist	No
3rd day	5. Neuropsychological assessment (3rd part)	Satu, neuropsychologist	No
3rd day	6. Feedback of the MIM with mother	mother, neuropsychologist	Yes
15th day	7. Speech pathologist's assessment interview	Satu, mother, speech pathologist	Yes

15th day	8. Speech pathologist's assessment (1st part)	Satu, speech pathologist	No
18th day	9. Feedback of neuropsychological assessment	mother, father, neuropsychologist	Yes
23rd day	10. Speech pathologist's assessment (2nd part)	Satu, speech pathologist	No
29th day	11. Speech pathologist's assessment (3rd part)	Satu, speech pathologist	No
29th day	12. Feedback of the speech pathologist's assessment	mother, Satu, speech pathologist	Yes
30th day	13. Child neurologist's assessment	Satu, father, neurologist	Yes
30th day	14. Neurological nurse's advice for the EEG	Satu, father, nurse	No
30th day	15. MIM with father	Satu, father	Yes
30th day	16. Feedback of the MIM with father	father, neuropsychologist	Yes
31st day	17. Network meeting	mother, father, neuropsychologist, speech pathologists, preschool teacher, personal assistants (present & prospective), special education coordinator	Yes
60th day	[.EEG]	Satu, mother, father	No
67th day	[.Child neurologist's letter about EEG results]	neurologist	No
70th day	[.Mother's telephone call to the child neurologist]	mother, neurologist	No
80th day	[.Neuropsychologist's telephone call to the mother]74	mother, neuropsychologist	No
102nd day	18. Follow-up session	mother, father, Satu, neuropsychologist	Yes

Consent for the recordings was received by means of the researcher (i.e. myself, the assessment process's neuropsychologist) calling the parents to make an appointment and telling them about the recording. The parents brought the printed consent form that had been sent together with the appointment letter to the meeting. In the research consent, signed by both parents, they gave their permission to record discussions between the parents and the professionals during

the assessment process and to the use of the recordings' transcriptions for the research, once all material had been removed that would allow the identification of personal information[1] (Appendix 1, Information for the research candidate). The assessment consisted of a total of 18 separate sessions, including the three-session assessments of the speech pathologist and neuropsychologist. Eleven discussions with the parents were recorded, of which I transcribed nine. Sessions 3 and 15, video-recorded play situations used to assess the interaction between Satu and her mother and Satu and her father, were not transcribed , even though the professional did participate in the beginning by instructing the parent. The majority of the action, however, took place between the child and her parents. Altogether, the discussions during Satu's assessment process produced 7 hours of recorded material, which yielded 160 pages of transcribed material.

The findings from Satu's child neurological assessment were as follows. In the neuropsychological assessment Satu showed an average non-verbal deductive reasoning. Verbal reasoning was difficult to determine reliably due to problems with verbal expression and understanding. Satu made good eye contact and had good play and visual-motoric skills. The speech pathologist evaluated Satu's verbal skills to be clearly lagging behind in development. During play Satu was occasionally in good contact and interaction, but there were difficulties as well. Satu refused, acted spontaneously and reluctantly and, from time to time, turned her back on the professionals who were assessing her. Satu's diagnosis was formulated as a conditional "F80.8 Other developmental disorders of speech and language?"

The EEG revealed an abnormal finding, which the child neurologist concluded was connected with the special difficulties in verbal development. This finding did not lead to any medical action. Based on the assessment, the recommended rehabilitation was speech therapy as well as speech-supporting and alternative communication methods and the use of a personal assistant in a small day care group. These recommendations and what they meant in practice were discussed at the end of the assessment at the network meeting together with the parents, representatives from Satu's day care group, her local speech pathologist and the neuropsychologist and speech pathologist from the assessing team.

2.4 METHODS OF ANALYSIS

I analysed the recorded material and the transcriptions from child neurological assessment using methods applied in process research within psychotherapy, dialogical sequence analysis (DSA) (Leiman, 2004, 2012) and the assimilation model (Stiles, 2002, 2011; Stiles et al., 1992). The methodological starting point for this research was to replicate the strategy of Leiman & Stiles (2001) and Stiles et al. (2006) studies on client change in psychotherapy combining DSA and the assimilation model in a context other than psychotherapy.

[1] A summary of the findings in Finnish, based on a poster abstract, was provided to Satu's parents in 2008. They have not read the final English research reports.

2.4.1. Dialogical sequence analysis

Dialogical sequence analysis (DSA) is a theory-based, micro-analytic method for studying utterances (Leiman, 2004, 2012). The conceptual tools of DSA are used to denote and formulate internalized action patterns and reciprocal patterns mediated through utterances (Leiman, 2012). The theoretical concepts of DSA are based on Bakhtin's theory of utterance (Bakhtin, 1981, 1984), Vygotsky's theory of sign-mediated activity (Davydov & Radzikhovskii, 1985; Stetsenko & Arievich, 2004; Vygotsky, 1978) and the basic concepts of cognitive analytic psychotherapy (Fairbairn, 1946; Klein, 1926; Leiman, 1992; Ryle, 1992).

Dialogical sequence analysis was developed in the context of cognitive analytic therapy supervision (Ryle, 1992; Ryle & Kerr, 2002). In therapy, it is important to recognise as early as possible the patient's problematic patterns that maintain their problems. The path from the patient's verbal expression to their internalized action patterns has to be articulated in order to make the basis of these hypotheses visible for the therapist's being supervised (Leiman, 2004, 2012). DSA is not restricted merely to verbal utterances, but adopts a broad understanding of the concept of utterance. Human experience is expressed verbally as well as in several non-verbal ways: through facial expressions, gestures and, above all, the prosodic aspects of speech. The methods of human experience can involve physical sensations, orientations and emotional response. Physical expression (e.g. body language, tone of voice, tension headache, states of pain or anxiety, etc.) and the related emotional content is a way of uttering embodied experience.

The relationships and positions in and between utterances, in speech as well as in interaction, may be studied using the theoretical concepts of DSA. Human communication, discourse and interaction, in terms of the contained utterances as well as the sequences of dialogue, form DSA's subject matter, through which internalized action patterns can be studied. The utterances indicate the subject's psychological action patterns and experience, which can only be accessed indirectly (Leiman, 2011).

Dialogical sequence analysis is based on Mikhail Bakhtin's conception of the dialogical structure of utterance. According to the Bakhtinian view, the speaker, *the author*, is positioned in all utterances in relation to the recipient, *the addressee*, as well as *the referential object* (Bakhtin, 1981, 1984; Leiman, 2004, 2012). Every utterance has such a dual positioning, where not only the author and the addressee ("to whom") but also the author and the referential object ("what", the content of the utterance) are in reciprocal relation to each other. The content of the utterance as well as the recipient of the utterance are simultaneously on the speaker's mind and have a conscious or less conscious impact on the style and structure of utterance.

As a classic example of the interactive relationship between author, referential object and addressee, Bakhtin (1984, pp. 204-211) uses a passage in a letter written by Makar Devushkin, the main character in Poor Folk by Fyodor Dostoyevsky. In the letter, Devushkin describes his room, which in reality is but a small alcove at the back of the kitchen, to his loved one. Bakhtin describes how Devushkin, in fear of the shame and ridicule his sorry quarters would possibly bring on him in his own eyes as well as the eyes of his beloved, has also built other kinds of attitudes and commentaries into his description. Devushkin's position in relation to the referential object is mediated by the (actual and imagined) reaction of the addressees. In Bakhtin's example, the characteristics in terms of the content and style in Devushkin's letters convey the defensive answer to the (imagined) addressees' (anticipated) criticism.

In therapeutic discussion – in any dialogue between two people –in addition to the imagined addressees, the actual listener to the utterance, for example the therapist is 'present'. The patient/client adapts their choice of words and the content and style of their expression in relation to these two positions. In DSA, this dual positioning in utterance is referred to as the *semiotic position* (Leiman, 2012). Utterances are constructed in constant referential relationships between the author, the referential object and the addressee. According to Bakhtin (1984), the utterances also contain the history that has developed during the constant positioning process between the referential object and the different addressees. Since utterances only contain references to experiences, emotions and events, it is only possible to gain indirect information on them. Not even the researcher of utterances has access to the semantic 'truth' of these utterances or the possibility of reliably stating anything about their 'true' content (Leiman, 2012). However, DSA does start with the assumption that despite this, researchers can attempt to describe psychic phenomena and the 'object' that takes shape as the referential object of utterances. To achieve this objective, the theory of utterance needs to be backed up with the *theory of object* (Leiman, 2004, 2012).

In DSA's theory of object all human activity is viewed *object directed*. The acting subject and the object of activity position each other reciprocally. The *internal* and *external* actions are seen, in accordance with Vygotsky (1978), as structurally similar and *sign-mediated* (Leiman, 2012, pp. 130–131).

The basic concepts of DSA's theory of object are *dialogical pattern and dialogical sequence* (Leiman, 2001a, 2004, 2008, 2012).

The different positions of the dialogical pattern are referred to as the *position* and *counter position*. A person has adopted a certain position, in which case the object takes the counter position. Such patterns are, for example, *demanding–performing*, *coercive–adaptive*, *controlling–rebellious*, *hostile–helpless*, etc. The pattern demanding–performing may manifest as interpersonal, in which a person may be the object of the demands other people impose on them, or intra-psychic, where the person imposes demands on themselves. Other phenomena or situations may also take on a demanding position in a person's experience. A technical device may, for example, 'demand' that its functional principles are understood in order for a repair to be successful. A 'demanding' device can render the repairer in a helpless and incompetent position, which may even paralyse the person's ability to function in this regard or lead to the person avoiding even trying repairing actions that might convey incompetence.

The object is portrayed to the subject differently depending on the subject's position. On the other hand, the object also determines the position. It is a constant relationship that moulds observations and actions (Leiman, 2012). The subject's changing positioning to objects during a period of time forms *dialogical sequences* (Leiman, 1997). These movements may include shifting from the position to the counter position, or to an alternative response mode, or disruptions that change the position or pattern to another (Ryle, 1997). For example, the demanding other in relation to oneself (in the pattern *demanding–performing*) may evolve from performing to exhaustion and toil, in which case the tone of demand has become cruel (*slave driver–plodder*). This, in turn, can lead to a martyr position in relation to the tyrant (*mistreating–victim*) or, alternatively, a rebellious position (*mistreating–rebellious*). The dialogical sequence can go on and on (Leiman, 1997, 2001a, 2008).

DSA denotes all psychic action and experience as positioned. Also the observation of one's own action, where the object of observation is inner action (such as feelings and thoughts) or external behaviour, is positioned as psychic action (Leiman, 2012). In depression, it is typical that the patient observes their own actions critically and judgmentally. One could say that in such cases, *self-observation* has a critical tone or that the patient has adopted a critical and demanding position, from which they make judgmental and belittling observations of their own actions, which, in turn, may contribute to the on-going experience of exhaustion and powerlessness. In clinical work, DSA has been applied within cognitive analytic psychotherapy as a conceptual tool for structuring and detecting and denoting the patient's problematic patterns in therapy supervision based on recordings from therapy sessions. In the field of guidance and supervision, the DSA-based working method of dialogical guidance and supervision (DON) has been used for study guidance and student group guidance (Koivuluhta & Puhakka, 2013; Puhakka & Koivuluhta, 2013).

Within psychotherapy research, dialogical sequence analysis has thus far been used as a method for *case formulation* (Eells, 1997, 2007b, 2009; Eells & Lombart, 2004; Sturmey, 2009a, 2009b), for studying development taking place in the course of therapy (Lahti-Nuuttila, 2011, Makkonen, 2004; Stiles et al, 2006; Tolonen, 2011), for studying breaks occurring in the course of therapy (Gersh et al., submitted; Lilja & Leiman, 2010), for studying the targeting and accuracy of therapists' interventions (Leiman & Stiles, 2001; Zonzi, 2009; Zonzi et al., 2014) and as a method for denoting the whole gamut of ways of action and protection of severely traumatised patients which manifest during the preliminary interview for therapy (Russell-Carroll, 2012). Kaunisto, Estola, & Leiman (2013) have applied DSA in a group situation, where they observed a single group member's development during the course of the teachers' peer group and group meetings' meaning for the studied teacher.

When DSA is used as a research method, the analysis usually does not proceed according to a pre-formulated process chart or heuristics (Leiman, 2012). Due to the diversity of utterances, it is difficult to classify and define the formal or contentual characteristics of the units of analysis. The length of utterances can vary from single sounds and pauses to utterances that are several paragraphs long. In addition, the referential objects of utterances may, in psychotherapeutic discussion in particular, be very hard to discern or note. Therefore the conventional approach in qualitative content analysis of classifying transcription material based on the content of utterances or single words is not applicable in the case of DSA (Leiman, 2004, 2012).

As a *transcription-based method of analysis*, DSA shares characteristics with conversation analysis (Peräkylä, Antaki, Vehviläinen, & Leudar, 2008; Peräkylä & Sorjonen, 2012). Conversation analysis was developed within the ethnomethodological approach in sociology (Garfinkel, 1967; Sacks, 1992a, 1992b; Sacks, Schegloff & Jefferson, 1974), as a method for studying the construction of social interaction. Conversation analysis is, like DSA, a theory-based method for analysing interaction. Conversation analysis sees the sequential construction through the rotation of the speakers' turns as a central characteristic of conversational interaction (Peräkylä, 2008; Schegloff & Sacks, 1973;). The emotional aspects of interaction have traditionally fallen within the sphere of conversation analysis (Peräkylä & Sorjonen, 2012). Conversation analysis can be used to denote the concrete interaction practices through which emotions are conveyed in everyday interaction situations and institutional contexts (Peräkylä, 2012). Recent studies within

conversation analysis have defined emotions as taking a stance (Goodwin, Cekaite, & Goodwin, 2012). This resembles DSA's denotation of the author positioning themselves in relation to the addressee. However, conversation analysis differs from DSA in that the speaker's double-positioning in relation to both the addressee and the referential object (Bakhtin, 1981, 1984; Leiman, 2004, 2012) is less articulated. Conversation analysis does not include a theory of object (Leiman, 2012) outside social interaction. In conversation analysis, the notation for transcription is commonly based on the method used by Atkinson & Heritage (1984) and Jefferson (2004), which has its roots in psycho- and sociolinguistic research. In DSA, transcriptions are usually based on the Mergenthaler & Stinson (1992) transcription standards, which are commonly used within psychotherapy research.

In research dialogical sequence analysis is conducted in data session group. A data session group consists of clinicians who are familiar with and trained in both cognitive analytic therapy and DSA. Similar to other transcription-based methods, such as conversation analysis (Peräkylä et al., 2008), DSA-analysis involves familiarising oneself with the recordings and transcription as the first step of the analysis process. In DSA, this stage proceeds from identifying thematic unities defined by the research problem to a more detailed micro-analytical study of these unities. The analysis begins by identifying the utterance's *addressee(s)* and *referential object*. This is followed by searching and finding reciprocal positions in the material – the *position* from which the person observes their situation, and the related *counter position*. From discerning single positions, the analysis proceeds to observing dialogical sequences, in which patterns change and transform into each other in interaction (Leiman, 2012). The expressive characteristics of utterances, such as intonation, tone of voice, inflexion, or pauses in utterance, have an important role in the micro-analysis of the material (Leiman, 2004, 2012). They act as a clue to how utterances are constructed, where one utterance begins and how it ends. Expressive characteristics help to illustrate the tone and quality of positioning, identification with a certain position or a reflective relationship with a certain position, for example.

In the next stage of analysis, the researcher selects samples to be jointly studied by the team. The discussion in the data session group may diversely bring out the various nuances of the material. While constructing the initial formulation, the conversations end up with a certain formulation, i.e. the team reaches a consensus about the positioning that is detectable in the material sample. The material samples that best illustrate each individual case or research problem which are to be selected for the final report are chosen during the data session team work. In Chapter 2.4.3. Analytic procedures, I will describe in more detail the process of DSA in the sub-studies, which are reported in the articles.

2.4.2 The assimilation model

The assimilation model (Stiles et al., 1992) is based on the client's subjective and experience perspective which is formulated through the client's utterances as well as denoting changes in perspective (Leiman & Stiles, 2001). Leiman & Stiles (2001) and Stiles et al. (2006) have combined this subjective perspective with the DSA formulation, which denotes the client's problematic patterns. The triangulation of these different perspectives (Leiman & Stiles, 2001; Stiles et al., 2006) was used to study the therapist's interventions in relation to the patient's original prob-

lematic patterns as well as the consequences of these interventions in regard to the patient's development (Leiman & Stiles, 2001; Stiles et al., 2006).

Based on these studies combining DSA and the assimilation model in the context of individual psychotherapy, I decided to test whether the assimilation model could be applied in my case material for studying the stages of development of the parent. I will describe the assimilation model in more detail in the following paragraphs.

The assimilation model is a methodological approach for psychotherapy research developed by William B. Stiles and his research group in the late 1980s to early 1990s (Leiman, 2006; Stiles et al., 1990, 1992; Stiles, 2002, 2011). It was developed as an alternative way to delineate the developmental event in psychotherapy and its stages from the perspective of the patient, in contrast to the leading objectives of that time: of observing psychotherapeutic change primarily from the perspective of comparing the accuracy of the therapist's actions and different interventions (Leiman, 2006; Stiles, 2011). The assimilation model switched the focus from the therapist's techniques or intentions to the patient's experience (Lepper & Riding, 2006).

The assimilation model sought to find a mediating solution in regard to *outcome research* and *process research* by offering a tool for studying and comparing the starting and ending situations of a single case and also taking into account the developmental steps taken during the process. The assimilation model challenged the correlational stance of outcome research, which sought to identify an implicit active ingredient of psychotherapy or single active factors of psychotherapy, as if they were drug ingredients (Leiman, 2006; Lepper & Riding, 2006). This research approach resulted in detailed classifications used to specify the therapist's actions and verbal process modes (VPM) (Stiles, 1992; Stiles, Shapiro, & Firth-Cozens, 1988), but these did not take into account the impact of situation-related factors on the process (Rice, 1992). Taking into account the restrictions of human interaction, and thus also the responsive nature of psychotherapy, has become the touchstone of the correlational approach (Ehrling, 2006; Leiman, 2006; Stiles 1994a, 1994b; Stiles, Honos-Webb, & Surko, 1998; Stiles & Shapiro, 1994;).

In the assimilation model, therapeutic change is illustrated as the client's individual developmental path (Stiles et al., 1992) and as transformative alterations of the initial situation or problem. The assimilation model represents the *development paradigm of therapeutic change* (Leiman, 2006; Stiles et al., 1992). The model illustrates therapeutic change as a development event that proceeds in stages, without committing itself to the concept system of a specific therapy approach regarding the nature of psychic action.

The basic concept of the assimilation model is the *problematic experience*. The client's change event is observed in relation to problematic experiences, which can be, for example, difficult or painful feelings, memories, attitudes, relationships or traumatic experiences. *Assimilation* refers to a process during which the patient's recurring problematic experience, which is beyond the reach of observation or experience, is brought into therapeutic observation and may gradually be integrated, i.e. assimilated, into the actions of the patient (Stiles et al., 1990, 1992). In assimilation, the schema (i.e. the patient's inner semantic system) 'takes it in', i.e. the new experience is integrated with the system of associations (Stiles et al., 1990). When problematic experiences cannot be integrated, they are warded off and end up out of reach of conscious observation. Non-assimilated experiences are distorted, rejected or repressed. During assimilation, the expe-

rience that was previously perceived as problematic now becomes a part of the schemata and is formulated as part of the patient's other experiences (Stiles et al., 1990, 1992).

The assimilation model formulates the qualitative changes of the problematic experience and the related emotional experiences into eight consecutive phases, which are illustrated through the Assimilation of Problematic Experiences Sequence (APES) (Brinegar, Salvi, Greenberg, & Stiles, 2006; Stiles, 2002). The assimilation phases are illustrated in Table 2.

Table 2: Assimilation of problematic experiences sequence

0. **Warded off / dissociated.** Client seems unaware of the problem. Affect may be minimal, reflecting successful avoidance. Alternatively, the problem may appear as somatic symptoms, acting out or state switches.
1. **Unwanted thoughts / active avoidance.** Client prefers not to think about the experience. The problematic experience emerges in response to therapist interventions or external circumstances and is suppressed or actively avoided. Affect involves unfocused negative feelings; their connection with the content may be unclear.
2. **Vague awareness / emergence.** Client is aware of the problem but cannot formulate it clearly – can express it but cannot reflect on it. Affect includes intense psychological pain – fear, sadness, anger, disgust – associated with the problematic experience.
3. **Problem statement / clarification.** Content includes a clear statement of a problem – something that can be worked on. The problem can named and described. Affect is negative but manageable, not panicky.
4. **Understanding / insight.** The problematic experience is formulated and understood in some way. The client reaches an understanding (a semiotic meaning bridge). Affect may be mixed, with some unpleasant recognition but also some pleasant surprise.
5. **Application / working through.** The understanding is used to work on the problem, to address problems of living. Affective tone is positive, optimistic.
6. **Resourcefulness / problem solution.** The formerly problematic experience has become a resource, used for solving problems. The formerly problematic material can be used flexibly. Affect is positive, satisfied.
7. **Integration / mastery.** Client automatically generalizes solutions; the formerly problematic experiences are fully integrated, serving as resources in new situations. Affect is positive or neutral (i.e., this is no longer something to get excited about).

At APES 0, the lowest level of assimilation, the problem is dissociated and out of reach or warded off. The patient does not recognise the problem as their own, or it may manifest itself as symptoms or changes in status. A problematic experience is coupled with strong avoidance or, for example, changing the subject in a conversation. If the avoidance or refusal to think about the problematic issue is strong enough, the emotions related to the problematic experience may be mild. At APES 1, the problem begins to take shape as unpleasant thoughts and emotional experiences. Emotions have a negative and undefined tone, yet they are clearer than the content of the actual experience. At APES 2, the patient is beginning to become aware of the problem, but still has difficulties defining it. Strong emotions – anger, hate and loathing – are associated with the problematic experience. APES 3 is characterised by the possibility of formulating the problem into something that can be worked on. The problem can be named and described. Emotions are still negative, but not panic-like. At APES 4, the problem can be observed from a new perspective and in new contexts. The emotions associated with the problematic experience are mixed. They include both unpleasant sides as well as 'aha' epiphanies. At APES 5, the problem can be worked on during everyday life, and the associated emotions are primarily positive and optimistic. APES 6 includes developing means and solution options for the problem. The prob-

lem-solving solutions are also assimilated into other actions. At APES 7, the problematic experience has become a resource. Integration manifests itself as change in the patient's attitudes and methods of action. The feelings associated with the problematic experience are positive or neutral.

APES denotes therapeutic change as a sequence of qualitative change (Brinegar et al., 2006; Stiles, 2006; Stiles & Brinegar, 2007). APES has previously been called Assimilation of Problematic Experiences Scale (Caro Gabalda, & Stiles, 2013; Stiles, 2002), and some researches still use this terminology (Caro Gabalda, & Stiles, 2013). The Assimilation of Problematic Experiences Scale has also been used as a quantitative evaluation scale (Detert, Llewellyn, Hardy, Barkham, & Stiles, 2006; Field, Barkham, Shapiro, & Stiles, 1994).

In research, assimilation assessment is usually conducted through a consensus procedure based on the assimilation analysis of the case's transcription material (see 2.4.3. Analytic procedures). When the research involves APES assessments by several evaluators, the unanimity percentages are reported and disagreements within cases are discussed. Validity research on the assimilation model has noted that the therapeutic development illustrated by the model is connected with findings achieved with standardised change indicators: when development was achieved on APES levels, change was also identified with the change indicators (Caro Gabalda, 2005; Honos-Webb, Surko, Stiles, & Greenberg, 1999; Stiles, 2002; Stiles et al., 1990, 1992) and, respectively, when no development occurred, neither did the indicators note any change (Caro Gabalda, 2005, 2006; Detert et al., 2006; Honos-Webb, Stiles, Greenberg, & Goldman, 1998; Stiles, 2002).

The assimilation model is not tied to any particular therapy approach. When it has been applied to observing therapeutic change in different approaches (Caro Gabalda, 2005; Honos-Webb, Stiles, & Greenberg, 2003; Honos-Webb et al., 1998; Honos-Webb et al., 1999; Varvin & Stiles, 1999), it has been noted that the different approaches are positioned differently in the assimilation sequence. Psychodynamic therapy concentrates on elevating problematic experiences into the sphere of self-observation (APES 0), attempts to avoid observing the problem (APES 1) and direct attention towards the contradicting aspects of the experience (APES 3) and clarification and observation (APES 3), and the formation of a new perspective (APES 4) to replace the previously problematic experience. Cognitive-behavioural therapy (CBT), on the other hand, focuses on the application of a new understanding of an issue that is already within the sphere of self-observation (APES 5), problem-solving (APES 6) or managing the problem (APES 7) (Caro Gabalda, 2005).

The assimilation model can be clinically applied to monitoring the development of a single client. The individual situation of a client who has sought therapy can begin at any level of assimilation. Development can proceed individually and can end up at any given APES level.

The assimilation model has been applied within psychotherapy in several case studies. The assimilation model has shed light on the more detailed therapeutic developmental progress in the different problem and assimilation stages (Brinegar et al., 2006; Caro Gabalda, 2005, 2006; Honos-Webb et al.,1998; Leiman & Stiles, 2001; Osatuke et al., 2005; Reid & Osatuke, 2006, Stiles, 2002; Stiles et al., 1990; 1992; 2006). Within Finnish research, the assimilation model has been applied in case studies by, e.g., Hartikainen (2000), Heiska (2010), Joutsiniemi (2010), Laine & Metsäpelto (1997), Laitila & Aaltonen (1998), Lähteelä, (2013), Makkonen (2003) and Ritala (2011).

The assimilation model has been further developed through case studies that have contributed to the theory (Stiles, 2005a, 2005b, 2007, 2010). The observations of individual cases have broadened, further worked, strengthened and fine-tuned the model as a developmental illustration of how therapeutic change progresses and how people change (Stiles, 2005a, 2005b, 2007; Stiles & Brinegar, 2007). For the assimilation model, this has meant a more detailed picture of the special characteristics of the different assimilation stages (Stiles & Brinegar, 2007; Varvin & Stiles,1999;), sub-stages (Brinegar et al., 2006; Reid & Osatuke, 2006; Varvin & Stiles, 1999), irregular development (Caro Gabalda & Stiles, 2013; Osatuke et al., 2005) and developmental leaps (Leiman & Stiles, 2001), as well as developmental setbacks, and also the therapist's role in these phenomena (Caro Gabalda & Stiles, 2013). According to Caro Gabalda (2005, 2006) and Caro Gabalda & Stiles (2013), therapeutic change does not always proceed in a straightforward manner, but can include setbacks or a kind of saw-tooth pattern (Caro Gabalda, 2006; Osatuke et al., 2005).

In addition to the schemata model (Stiles et al., 1990, 1992), other models of the assimilation model have also been formulated (Stiles, Honos-Webb, & Lani, 1999). In the 1990s, along with the postmodern change, Honos-Webb & Stiles (1998) created a *voices formulation of the assimilation model*, which was based on the theory of the *dialogical self* (Hermans & Dimaggio, 2004), which also began to gain a foothold in psychotherapy research. It denotes the traces of a person's experiences as *voices*, which are active actors in the person's *community of voices*.

Leiman & Stiles (2001) and Stiles et al. (2006) have combined the application of the assimilation model in monitoring development and dialogical sequence analysis in the micro-analysis of utterances. This has allowed a more in-depth analysis of therapeutic interventions. With the assimilation sequence, Leiman & Stiles (2001) followed the patient's stages of progress as a collaboration between therapist and client during the first visit. They sought to analyse how the therapist's interventions helped the patient to proceed in self-observation beyond the aspects that the patient had put together during the initial formulation. Regarding the assimilation model, the theoretical finding was that the patient achieved a higher APES level in collaboration with the therapist than the patient had reached by themselves. Leiman & Stiles (2001) adopted Vygotsky's concept of *zone of proximal development* to describe an event where the patient may proceed from one assimilation stage to another when aided by the therapist. The transition in therapist-aided observation may be greater than the patient would be able to achieve independently.

In this research, the assimilation model was applied in the analysis of conversations during a child neurological assessment process. Unlike in psychotherapy, where the assimilation model has served as a tool for observing intra-psychic change, the material of this research consists of interaction material, the relationship between parent and child, and how the parent describes the child in their utterances and how the parent responds to the child. In other word, the methodological starting point was to test how the combination of DSA and the assimilation model (Leiman & Stiles, 2001; Stiles et al., 2006) could be applied in analysing the interaction material from a child neurological assessment process. In the first sub-study, the experimental application of the assimilation model in the analysis of interaction material produced theoretical results, through which theory-based case study (McLeod, 2010; Stiles, 2005a, 2005b, 2007, 2010) ended up crystallising the orientation of the whole research. In theory-based case studies, the material of an individual case – in Satu's case, the parent's change observed during conversations be-

tween the parents and the professionals as well as group discussions – shed light on a theoretical phenomenon – achieving empathic stance and its phases – from a new perspective.

In the following section, I will describe how the methods used in this research and presented above (dialogical sequence analysis and the assimilation model) were used to analyse the transcriptions from Satu's case, and how the case formulation of the initial situation and the *assimilation analysis* was conducted in practice.

2.4.3 Analytic procedures

The analysis of Satu's transcription analysis began 1.5 years after the clinical assessment process had ended and the original tape material was gathered. I had transcribed the tape material from Satu's assessment process using the transcription method of Mergenthaler & Stinson (1995). Satu's assessment process included 9 meetings between the parents and the professionals, which amounted to 7 hours of tape and 160 pages of transcription.

The analysis of the recordings and their transcriptions was conducted in three stages. The first stage included an *assimilation analysis* in accordance with the classic assimilation model. The second stage consisted of a micro-analysis of the events of the first meeting based on the theme identified in the assimilation analysis, which was further developed into an *initial formulation* of the preliminary interview's problematic pattern utilising DSA. In the third stage, I selected the samples which manifested the problematic pattern that I had identified with DSA throughout the assessment process. The assimilation evaluations of these samples were then assembled. In the data session team, we selected the samples to be used in the final report of the first sub-study. After these stages and in accordance with the findings from the first sub-study, I concentrated on analysing, based on the DSA's initial formulation, the dialogue between the neuropsychologist and the mother at the third assessment visit, as well as the assimilation stages and the interventions of the neuropsychologist through which the mother began recognise her own role in the problematic pattern. This formed the second sub-study. The third sub-study concentrated on the network meeting. In addition, the samples for the two latter sub-studies were selected.

The first stage of analysis and the assimilation evaluations were conducted in collaboration with the two other authors of the articles. I, the researcher and the neuropsychologist in Satu's assessment process, had 20 years' experience in child neuropsychology and 15 years' in cognitive analytic psychotherapy, but no previous experience in using the assimilation model as a method. The two other researchers who took part in the assimilation analysis, on the other hand, had a great deal of experience in formulating assimilation assessments. The second and third stage of analysis and the subsequent dialogical sequence analysis was conducted in a data session team comprising experienced and DSA-trained clinicians. In the first DSA phase, the data session team included three psychotherapists, one clinical psychologist, two doctors and three Master's students in psychology. Three experienced psychotherapists from the original data session team participated in the DSA for the third sub-study.

The assimilation analysis is fairly laborious as a transcription-based analysis method. Stiles et al. (1990) describe its stages as follows:

In the *first stage*, the whole material is read through and catalogued according to themes and topics in relation to the object. After the initial reading, the material is catalogued in more detail.

The exact location of the catalogued themes/topics in the transcription is noted. Attitudes to objects may involve, for example, emotions towards another person.

In the *second stage*, the problematic experience is identified in the material. The focus of objective is on epiphanies or new perspectives that show a new, insightful understanding. Such events include both certain cognitive elements as well as characteristics of emotional tones: the emotion becomes more positive, the epiphany produces more material, and the client can experience a closer relationship with the therapist.

The *third stage* includes searching for topics that have a thematic relation to the problematic experience of which the client has gained new understanding. The related samples are selected from the transcriptions.

In the *fourth stage*, an assimilation analysis is conducted for these identified themes, i.e. the researcher evaluates which phase of the assimilation model each stage complies with.

In this research, the assimilation analysis was conducted in accordance with the so-called classic method of the assimilation model described above (Stiles et al., 1990, 1992; Stiles & Angus, 2001; Stiles & Osatuke, 2000). The researcher read the 160-page transcription material several times and drew up initial catalogues of what was discussed during the sessions. Thereafter, more detailed theme catalogues were formulated: the attitudes to the object discussed during the session were catalogued. The cataloguing was a laborious phase. The parents could, for instance, express pride or anger in relation to Satu's actions. These were catalogued as separate themes. The nuance and quality of the attitude towards the object (e.g., was the attitude towards Satu's actions negative or positive in nature) were central aspects in the assessment. Table 3 illustrates an example of the topic catalogue from Satu's case and the related objects, as well as attitudes towards the objects and tones of attitude.

In Satu's material, the theme of *Satu's behaviour and rebelliousness* was highlighted as the problematic experience. Related to this theme, new understanding was gained and change took place in attitudes towards the object, which had manifested as negative in the initial phase of the assessment process, during the assessment process and by the follow-up visit. This theme was also selected for the triangulated DSA, in which the problematic initial pattern was identified in the first session. The problematic interaction pattern which manifested during the first assessment session acted as the case formulation, whose development and change during the child neurological assessment process was studied in the first sub-study utilising the assimilation model (Stiles et al., 1992). Nineteen topics around the problematic initial pattern were identified. The fourth stage of the assimilation analysis was used to analyse these. The three authors of the first sub-study acted as the evaluators, conducting the assimilation evaluation independently and discussing differences in opinion. Through dialogical sequence analysis, the problematic experience was formulated into a more detailed interaction pattern, where the parent's own role in the observation of the pattern was warded off (APES 0). During the understanding/insight –stage (APES 4), the development of the parent showed the possibility of flexibly moving between both positions of the pattern, i.e. the child's and the parent's own perspective.

Table 3: Example of theme catalogue from Satu's case

Location	Topics, attitude to object	--/-/-+/+/++	Object
585	M: concentrates well on books, no hyperactivity	+, -+	Satu, concentration
592,594	M: takes time to make contact	+	Satu, contact
596	M: Yeah, yeah	++	N's description S / speech
598	M: Yeah, she's got a lot of this in her play	++	N's description S / speech
602	M:Yeah,some locks opened, there's speech	++	N 's description S / speech
604	M: but then again not that bad	-+	Satu's situation
605	M:Satu'sstrengths and weaknesses	+	Satu's skills
606	M: and motor skill things	++	N's description S /development
608	M: Satu probably doesn't have a hyperac-tivity disorder	-+	Satu's development
610	M: there are all kinds of thoughts	-	Satu's development
612	M: I've just thought of things like these	--	own worry
616,618	M: that what else do we need	--	own worry

The numbers refer to the location in the transcription. M=mother, N=neuropsychologist, S= Satu. A rough assessment of the tone in attitude to the object is expressed by the sequence --/-/-+/+/++.

In practice, the DSA-based data session team work and the microanalysis of the selected text samples proceeded by first identifying the *referential object* and the author's *position in relation to the referential object*, as well as identifying the possible *dialogical patterns* and *sequences of reciprocal patterns* in utterances, i.e. fluctuation in the positioning in relation to objects and from one position to another as expressed in utterances. This formulation was achieved through consensus-based collaboration, but the data session team work also included the different tones of utterances, their 'voices', and how they resonated with individual team members.

Upon closer examination of the parent's positioning towards the child during the first session of Satu's assessment process, the neuropsychologist's interview, the data session group identified a clear problematic interaction pattern between Satu and her parents. It manifested between Satu and her mother, in particular. This pattern was formulated as the dialogical sequence of the pattern, which was illustrated as a diagram shown in Figure 1.

In the initial pattern, the problem was seen to lie only with the child, whereas the parent's role was not discernible. Typical for the pattern was the parent's strong transition to a controlling position mid-utterance. The parents used controlling methods without reflecting on their own actions. In this pattern, the parent's observation of the child was coupled with a controlling position, from which the parent was unable to form an empathic (i.e. taking the child's perspective into account) relationship with the child in the initial situation.

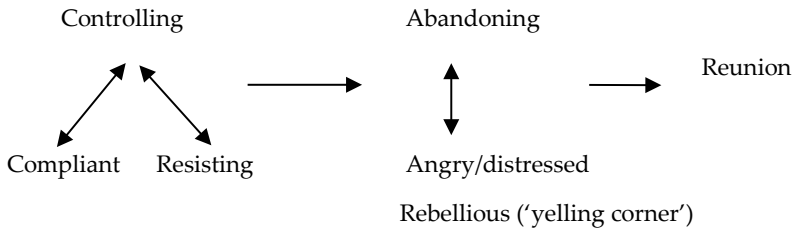

Figure 1. Two dialogical patterns

The first sub-study of this dissertation (Tikkanen, Stiles, & Leiman, 2011) presents the excerpts that act as the basis for the DSA data session team's formulation of this pattern.

3 Findings – Summaries of the original studies

The empirical section of the research consists of three articles, which each form their own sub-studies of Satu's assessment process.

3.1 STUDY I

Tikkanen, S., Stiles, W. B., & Leiman, M. (2011). Parent development in clinical child neurological assessment process: Encounters with the assimilation model. ***Psychotherapy Research, 21*****, 593–607.**

The study focused on the child neurological assessment process from the perspective of the parent whose child is being assessed. The sub-study sought to find out how the parent's perspective changes during the assessment process and the related encounters with the assessment team professionals, which included initial interviews and feedback sessions. The study asked, from a process research approach, which and what kind of stages lead to the parent's possible development.

The first sub-study followed the phases of the development of the parent's perspective and the formation of an empathic relationship. The observation period began from the problematic initial pattern to the three-month follow-up in four-year-old Satu's assessment process. Satu had been referred for multi-professional assessment because of speech development and contact problems. Based on the findings, she was diagnosed with "Other developmental disorders of speech and language?" The neuropsychologist's examinations showed that her performance in non-verbal and visual-motoric skills was average. Verbal performance was difficult to determine reliably due to problems with verbal expression and understanding.

Satu was chosen for this research because of the clear problematic pattern between the parents and child that manifested during the preliminary interview. Satu's assessment consisted of a total of eighteen meetings, including Satu's examination visits. The case material of the sub-study consisted of nine videotaped and transcribed subsequent meetings between the professionals during the assessment process.

The interaction patterns were studied using dialogical sequence analysis, which is a conceptual tool and method for structuring and constructing case formulations on dialogical patterns and positioning in relation to the object which are expressed through utterances (Leiman, 2004, 2012; Leiman & Stiles, 2001). The interactive pattern between the parent and the child, which started to manifest itself during the assessment process's initial situation and the first session, was formulated with the data session team by applying DSA. The sub-study applied the assimi-

lation model (Stiles et al., 1992) to observe the phases of change in the problematic pattern as a theoretical framework.

According to the findings, the initial situation was perceived from the parent's perspective solely as the child's behavioural issues and rebelliousness. With dialogical sequence analysis, this was formulated into the interaction pattern *coercive, controlling – rebellious*, in which the parent adopted the position coercive/controlling in relation to Satu, who rebelled against her parent's actions. As the assessment process proceeded, the parent's own role in the pattern was also brought into empathic observation and as the object of self-reflection. As a result, the parent's sense of otherness in relation to the child was also developed. The material showed that the professional's role in supporting the dawning understanding of otherness and in targeting attention towards the child's perspective was central at the beginning of the process. By the three-month follow-up meeting, the parents had developed new methods in relation to the problematic pattern. The parents had started to perceive the child as an individual actor and not solely as someone who was defined through the parent's position.

The first sub-study showed that a clinical child neurological assessment process can have therapeutic impact. The intense analysis of an individual case illustrated the phases through which the mother's change of perspective – from her own perspective to an emphatic stance and taking into account the child's perspective – happens. In the light of the sub-study's case material, this development was preceded by the formation of an emphatic relationship with oneself as well as developing a new observer position through which it was possible to observe the perspectives of the different parties of the interaction pattern.

3.2 STUDY II

Tikkanen, S., Stiles, W. B., & Leiman, M. (2013). Achieving an empathic stance: Dialogical sequence analysis of a change episode. *Psychotherapy Research, 23*, 178–189.

The study subject of the second sub-study was the same child and assessment process as in the first sub-study. The second article described the phases of forming an empathic stance during the feedback session for interaction, which was conducted in accordance with the Marschak Interaction Method (MIM) (Jernberg, 1991; Lindaman, Booth, & Chambers, 2000; Marschak, 1969).

The case material of the second sub-study was the videotaped and transcribed material from the above-mentioned feedback session between the parent and neuropsychologist. The common procedure for a MIM feedback session is that the parent is shown samples from a videotaped structured play situation between the parent and the child which illustrate successful interaction moments during the assessment (Lindaman et al., 2000). The excerpts selected for this sub-study were from the very beginning of the feedback session.

The study utilised the same initial formulation that was identified using DSA in the first sub-study. In the interaction pattern *coercive, controlling – rebellious*, the parent adopted a coercive/controlling position in relation to Satu, who rebelled against the parent's actions. Dialogical sequence analysis was also applied to analyse how the parent positioned herself in relation to

the discussed topic, and how the neuropsychologist during he own turn directed attention towards Satu's role as well as the parent's role in the pattern being observed.

The findings described the phases of developing an emphatic stance during the MIM feedback session. The focus of attention was initially the mother's controlling position, on the basis of which Satu's behaviour was perceived as resisting rebelliousness. The focus was also on the mother's own negative stance towards her controlling actions. This was followed by the shift of observation on Satu's perspective and by the neuropsychologist formulating the whole interaction pattern. The mother proceeded to observing her own, more flexible methods and their consequences for Satu. Thereafter the mother went on to observe the consequences of the controlling position for herself. The neutral observer position was beginning to take form, which manifested as the mother's ability to observe both her own controlling and angry action and Satu's perspective on it. The mother's negative emotions coupled with her expressions of anger began to form into guilt that could take Satu's perspective into account. Along with the recognition of the interaction pattern *("Two women with a strong will at home, it is, I tell you, a tough thing.")* The mother was able to formulate a solution for her own role in the problem, namely, to try to control her own temper. The last sample of the findings pictured the mother's emphatic stance towards Satu while watching the video material.

The second sub-study confirmed what had already been observed in the first sub-study: the successive relationship between emphatic self-observation and emphatic observation of the other in therapeutic change. In addition, this study showed how the transition from one's own perspective into taking the other's perspective into account was mediated by a new kind of observer position. This position enabled the observation of the whole interaction pattern in which one took part, as well as the consequences of one's actions towards oneself as well as the other.

Based on its interactive case material, the second sub-study highlighted, in relation to the assimilation model, that a problematic experience can be initially identified in the context of interaction with the other (in this case, the child), and only thereafter with oneself and one's own actions.

3.3 STUDY III

Tikkanen, S. & Leiman, M. (2014). Resolution of an impasse at a network meeting: Dialogical sequence analysis of the use of a shared formulation. ***Counselling Psychology Quarterly*** **27, 154–173.**

The third sub-study concluded the trilogy on Satu's assessment process, this time utilising material from the day care discussion organised at the end of the assessment. The third article studied the formation of an empathic stance and the fluctuation between the parent's own perspective and the other's perspective at the group level.

Dialogical sequence analysis was applied as a method for the initial formulation as well as for analysing the videotaped and transcribed interaction during the group meeting.

The study's findings showed, through DSA and material samples, how the problematic interaction pattern between parent and child was, in this context, manifested as a conflict during between the parents and the day care personnel. The conflict escalated to a point where it was

suggested that Satu move to a different kindergarten group. The sub-study described the different formulations of the problematic interaction pattern that the neuropsychologist used during the meeting and the impact that they had on the progress of the on-going interaction. The pattern *controlling–resisting* had already been shared with the parents at the beginning of the assessment process.

Between the parents and the special education coordinator, the pattern *coercive–surprised/helpless -> resisting* took form. Satu's perspective on the new and odd-feeling situation of change, which Satu's mother brought up during the discussion, was not observable from the special education coordinator's professional and *coercive* position, but was rather warded off. The neuropsychologist formulated the parents' position 'here and now' during the discussion: *surprised/shocked/helpless*. A little later, the neuropsychologist asked the special education coordinator, from a *helpless* position, what other possible options there were for the suggested change. This was followed by the mother adopting a *resisting* position. The neuropsychologist illustrated the pattern *coercive–resisting* between the parents and the special education coordinator from Satu's perspective. As a result of this formulation, change began to take place both in the parents' and the special education coordinator positions towards a more emphatic stance and taking the other's perspective into account.

The formulations of the neuropsychologist during the discussion had both direct and indirect addressees. During the mediation of the formulations, the parents had the opportunity to observe the pattern *coercive–resisting*, with which they were familiar from interaction with Satu, from an outsider perspective in the 'here and now' situation during the meeting. The events of the meeting often referred to the possibility of the experience of *surprise*, *shock* or *helplessness* in a new situation as the underlying cause for the expressed behaviour. The third sub-study denoted the qualitative change in the parent's positioning and the parent's transition into the observer position, from which they could observe empathically both their own and the child's perspective in a problematic situation.

In the third sub-study, the DSA-based case formulation that had been identified during the data session was utilised as a methodical triangulation for the professional's formulation during a clinical assessment situation. The third sub-study showed that dialogical sequence analysis can also be applied to studying on-going interaction in a group situation, which brings the direct and indirect addressees of utterances within the focus of analysis.

4 Discussion

4.1 MAIN FINDINGS

The research studied the parent's change during the child neurological assessment process by utilising the assimilation model as the theoretical framework for studying therapeutic change. The parent's development was formulated as a qualitative change in the parent's positioning: as an assimilation of the problematic experience and as the formation of an empathic stance. The intensive, theory-based analysis of an individual case, divided into three sub-studies, illustrates the phases through which the assimilation of the problematic experience and the change from one's own perspective into also understanding the other's perspective happens. The changes were observed along the entire assessment process as well as during individual sessions (MIM feedback session, network meeting). Dialogical sequence analysis (Leiman, 2004, 2012) acted both as a method for formulating the initial situation and the analytical tool for studying the on-going interaction in meetings between the parent(s) and the professional and group meetings.

At the beginning of the assessment, what was understood solely as the child's behavioural problems and rebelliousness was formulated as the interaction pattern *coercive/controlling–rebellious* between parent and child. From the parent's controlling position, Satu's behaviour was perceived only as rebellious and misbehaving. The parent's own role in maintaining the problematic pattern was not within her observation (APES 0 = *dissociated, warded off*). As the assessment proceeded, the parent's own role in the pattern was also brought into empathic observation and as the object of the parent's self-reflection. As a result, the parent's sense of otherness in relation to the child was also developed. By the three-month follow-up meeting, the parents had started to perceive the child as an individual actor and not solely as someone who was defined through the parent's own position. On the assimilation model scale, the parent's development reached APES 5 (*application, working through*), even close to APES 6 (*resourcefulness, problem solution*), by the follow-up session.

4.1.1 The individual outcome of the child neurological assessment process for the parent

The objective of working with children and families is to support and further such change in the parent that is beneficial for the child's development and rehabilitation. The research at hand shows that during the child neurological assessment process, change occurred in the interaction between parent and child and in the parent's self-observation that also had an impact for the child. This change manifested as the parent's new ability to observe both their own and their child's actions empathically. As a result of this new observer position, the parent was able to develop new methods of interaction with the child. This depicts the individual outcome of the child neurological assessment process (Leiman, 2006) for the parent.

The scientific literature on the outcomes and effectiveness of different therapeutic and rehabilitation interventions is vast (Lambert, 2004; Norcross, 2002; Roth & Fonagy, 2006). Research on the efficacy of treatment interventions and comparisons between the efficacy of different treatments has been of particular scientific interest (Persons, 1991; Poston & Hanson, 2010; Wilson, Gracey, Evans, & Bateman, 2009). The impact of the assessment process or clinical evaluation period, on the other hand, has been less well-researched, even though the importance of assessment and the assessment period has, in essence, been gradually acknowledged (Poston & Hanson, 2010).

During recent years, different therapeutic models of assessment have been developed in order to challenge the traditional 'information gathering model' of assessment and highlight the interactive and collaborative characteristics of the psychological assessment process (Finn, Fischer, & Handler, 2012a, 2012b; Finn & Tonsager, 1997). Some therapeutic assessment models have even developed into their own brands, e.g. Therapeutic Assessment (Finn, 2007), Collaborative/Therapeutic assessment (C/TA) (Finn, Fischer, & Handler, 2012a, 2012b) and Therapeutic Model of Assessment (TMA) (Hilsenroth, 2007). Their outcomes in relation to traditional assessment methods or assessment processes have been compared using the RCT (randomised controlled trials) method, as with treatment interventions (Poston & Hanson, 2010).

Therapeutic models have also been applied and their outcomes researched within child and adolescent assessment and feedback practices within neuropsychology assessment (Gorske, 2008; Gorske & Smith, 2009, 2012; Hamilton et al., 2009; Smith, 2010; Tharinger, Finn, Gentry, et al., 2009; Tharinger, Finn, Hersh, et al., 2008; Tharinger, Finn, Wilkinson, & Schraber, 2007). Parents who have undergone the neurological assessment process of their child have described positive change, a better understanding of their child, improved interaction with the child, improvement in the child's self-esteem and calmer behaviour of the child (Human & Teglasi, 1993).

The therapeutic assessment process has been researched using time series analysis in single-case study designs. These studies have mainly served to show that assessment processes may take very different, individual paths and schedules of development in regard to the benefit gained from the therapeutic assessment process (Smith, Finn, Swain, & Handler, 2010; Smith & Handler, 2009; Smith, Handler, & Nash, 2010; Smith, Nicholas, Handler, & Nash, 2011; Smith, Wolf, Handler, & Nash, 2009). These researches have thus far been unable to denote the mechanisms for positive outcomes of therapeutic assessment or how change takes place (Smith et al., 2010).

The research at hand demonstrates that the methods used in psychotherapy process research and within the developmental paradigm are applicable in examining the outcomes of an assessment process (Leiman, 2006; Stiles, 2002; Stiles et al., 1990, 1992; Strupp et al., 1988; Toukmanian & Rennie, 1992). The methods used in this study, dialogical sequence analysis and the assimilation model, may also be used for illustrating and formulating interaction phenomena between parent and child as well as the parent's process and the fluctuations within it, also by taking into account the case's individual special characteristics.

The findings of the research show that the child neurological assessment process has therapeutic outcomes for the parent. How the parent's change occurred along the assessment process was examined in the sub-studies of the research.

4.1.2 Theory-based case studies

The research consists of three separate sub-studies, which are theory-based case studies (McLeod, 2010; Stiles, 2005a, 2005b, 2007, 2010). This refers to a case study that seeks to illustrate, complement or test a theory using the material from an individual case (McLeod, 2010; Stiles, 1993, 2005a, 2005b, 2007, 2010).

According to the inductive conception of science, an individual case and the change observed within it does not, as such, form an adequate base for producing generalisable knowledge on the impacts of child neurological assessment processes for the parent. Statistical testing of hypotheses based on adequate observational data and theoretical case study are both empirical methods for scientific research. Both approaches have taken theory as their starting point. The research material – statistics or qualitative case material – may offer elements for 'testing the theory' or for quality control (Stiles, 2005a, 2005b). Research produces observations that can be compared against the theory. In other words, they can confirm or falsify, or strengthen or weaken the theory according to hypothetico-deductive research principles (Stiles, 2005a, 2005b, 2007, 2010). They can also broaden the theory, develop it further, or cultivate it to be more detailed or 'penetrable' (Stiles, 2005a, 2005b, 2007, 2010). The theory is thus transferrable and also testable in other cases (McLeod, 2010, p. 157).

Stiles (2005a, 2005b, 2007, 2010) has proposed that abductive reasoning, i.e. 'inference to the best explanation', is the epistemological starting point for theory-based case studies (Peirce, 1994; Niiniluoto, 1983). Within abduction, a theory is worked on, moulded or broadened in order to better comply with observations (McLeod, 2010; Stiles, 2005a, 2005b, 2007, 2010). Abductive criticism is used to test how well a theory fits to and explains the accessible evidence material and how it complies with underlying assumptions. The conclusion of abductive reasoning is a reasonable assumption, but not deductively valid (Niiniluoto, 1983).

In general, abductive reasoning plays an important role in qualitative research. In case study reports, both the researcher's conclusions and the evidence material of the case, based on which the researcher has reached the conclusions, are visible to the reader. The reader draws their own conclusions based on the presented material (McLeod, 2007, 2010).

In this research, the assimilation model's formulation of the change as the assimilation of a problematic experience was examined based on observations from a single case (McLeod, 2010; Stiles, 2005a, 2005b, 2007, 2010). The objective of a theory-based case study is thus not to apply a specific theory to the case or to illustrate the theory through a specific case, but to explore and develop the theory or its conceptual formulations through the versatile material from an individual case. The assimilation model which depicts change as the assimilation of a problematic experience works as the theoretical framework for these theory-based case studies. The studies were not, however, about testing theory-derived hypotheses, but rather about studying the observations provided by the material against the theory and about making possible new findings. These findings were not foreseeable; in other words, the studies were not discovery-orientated (McLeod, 2010). The findings of the theory-based case studies are the main findings of this research.

The starting point of this research was to test the application of the assimilation analysis (Stiles, 2002; Stiles et al., 1990, 1992) in a single body of material that did not fall within the context of psychotherapy (Leiman & Stiles, 2001; Stiles et al., 2006), but was instead a child neuro-

logical assessment process. The assimilation model had previously been primarily used in psychotherapy research for observing intra-psychic change. In this research, this methodical decision produced theoretical findings on the development of the stages in forming an empathic stance, which enriched the assimilation model.

The findings from the first sub-study showed that the parent's development progressed from the APES 0 position of the initial situation to APES 5–6. Initially, Satu was only perceived from the mother's controlling position, and the mother's own role in the pattern was warded off. By the follow-up meeting, the mother had achieved better control of her own actions, developed new methods of interaction with Satu and perceived Satu as a separate actor.

In the first sub-study, the observer position was depicted as a place from which one can adopt an empathic stance toward both oneself and the other. According to the findings, achieving an empathic stance required the understanding of otherness and the perception of the other's separate perspective, which was achieved at APES 4, at the earliest. The central theoretical finding of the study was that obtaining an empathic stance towards oneself preceded the formation of an empathic stance towards the other. Maintaining the empathic stance did not come naturally or independently at first, but required the support of the neuropsychologist during the process.

The theoretical findings of the second sub-study complemented and reinforced the first sub-study's findings on the successive phases of developing intra-psychic and interpersonal empathy, as well as on the formation of the observer position at levels 3–4 of the assimilation model (Brinegar et al., 2006). The second sub-study presented a short episode from the MIM feedback session at the beginning of Satu's assessment process. It described in detail how the mother detached herself from the controlling perspective and adopted a neutral observer position. The mother began to grasp her own role in maintaining the problematic pattern and to acknowledge Satu's perspective in problematic situations. From the neutral observer position, the mother was able to observe both her own and her child's perspective on the problematic pattern, as well as her own actions and how they were perceived from Satu's perspective.

The theoretical findings of the third sub-study related to observing the formation of an emphatic stance in a group situation, the network meeting whose tense atmosphere formed a problematic pattern. The empathic description of the on-going interaction from the perspective of the child led to the de-escalation of the erupted conflict. The parent adopted the observer position, from which she could empathically observe both her own and the child's perspective in the problematic pattern.

The findings of the sub-studies denote the assimilation of a problematic experience through an observer position that enables the observation of the interaction pattern (with internal empathy or interpersonal empathy, and from the different perspectives of the parties), as well as the flexible transition between one's own and the other's perspective at APES 4. The findings complement the descriptions of APES 3–4 by Brinegar et al. (2006) by offering a new viewpoint: empathic stance towards one's own unassimilated sides (*internal empathy*) is achieved before an empathic stance toward the other (*interpersonal empathy*) is possible. Brinegar et al. (2006) demonstrate, using material from the individual therapy of two cases, the parallel and simultaneous development of internal empathy and interpersonal empathy (the patient's empathy towards their spouse). In this research, the problematic experience was formulated as a problemat-

ic interaction pattern between Satu and her mother, and therefore it is possible to illustrate the sequential development through the material of the same on-going process.

The theoretical findings that complement and comment on the assimilation model, described above, comply with the observations within psychotherapy research that successful therapy includes self-observation, self-reflection and the development of empathy (Barber & Sharpless, 2009; Bateman & Fonagy, 2004; Dimaggio, Semerari, Carcione, Nicolo, & Procacci, 2007; Dimaggio & Lysaker, 2010; Fonagy, Bateman, & Bateman, 2011; Fresco, Segal, Buis, & Kennedy, 2007; Levy, Clarkin, et al., 2006; Levy, Meehan, et al., 2006; Lysaker, Gumley, & Dimaggio, 2011; Rudden, Milrod, Aronson, & Target, 2008; Semerari et al., 2007; Steele & Steele, 2008; Yeomans, Clarkin, Diamond, & Levy, 2008).

In the mainstream of outcome research within psychotherapy, the most central finding related to empathy has thus far been the *empathy of the therapist* as an important outcome-related factor (Bohart, Elliott, Greenberg, & Watson, 2002). The question of how the therapist's empathy is conveyed and transformed into a successful therapeutic outcome has been pondered from several viewpoints (reviews: Bohart et al., 2002; Watson, Steckley, & McMullen, 2014). According to Rogers (1957; 1980), the therapist's empathy and acceptance improves the extent to which the patients acknowledge the value and importance of their own inner experiences. According to the hypothesis of Barrett-Lennard (1997), the therapist's empathy promotes the development of internal empathy. This can also be described as assimilating the therapist's voice as empathic self-observation and the observer position (Leiman, 2012; Mosher & Stiles, 2009).

The hypothesis that interpersonal empathy is also developed during the development of internal empathy (Barrett-Lennard, 1997) has been studied using correlative methods (Bohart et al., 2002). Not much empirical research has in fact been done on how self-reflection (or an empathic stance towards oneself, using the concepts of this research) and empathy towards the other are intertwined in the course of a therapeutic process. In addition to assimilation model based formulations (Brinegar et al., 2006), the relationship between self-reflection and the observation of the other has been studied, e.g., within the frameworks of mentalisation research (Fonagy, 1991; Fonagy & Target, 1996, 1997; Fonagy, Target, Steele & Steele, 1998) and psychotherapeutic metacognition research (Dimaggio et al., 2007; Semerari et al., 2007). Some empirical research on the relationship between self-reflection and the observation of the other has also been done, as well as process research (Gullestad & Wilberg, 2011; Semerari et al., 2007), but this research has been conducted with different methods than those used in this research.

Gullestad & Wilberg (2011) studied the *mentalisation* of one's own mind and the other's mind during the therapy of a bipolar disorder patient utilising the indicator of the *reflective function* (RF) (Steele & Steele, 2008), which is based on the Adult Attachment Interview (AAI) (Fonagy & Target, Steele, & Steele, 1998), and analysing its object dimensions (I/the other) and content dimensions (Choi-Cain & Gunderson, 2008). According to their findings, the patient was able to develop the reflective function during three years in therapy from the initial evaluation's questionable or low reflective function (RF 3) to the follow-up evaluation's ordinary reflective function (RF 5). The observation of oneself and the other developed at a different pace. The method used by Gullestad & Wilberg (2011) – broadening the traditional RF to include contents and objects – enabled them to highlight how the patient progressed more in reflecting their own mind during therapy than in understanding the other, e.g. their mother.

Semerari et al. (2007) used the concept of *metacognition* for formulating the understanding of one's own mind and the other's mind as actions, functions that are related but may also act separately. The clinical incidences of these actions may vary greatly in different psychological disorders (Semerari et al., 2007). Study of the self-observation and observation of the other as developments progress at a different pace during the therapeutic change procedure can be conducted using the Metacognition Assessment Scale, MAS (Semerari et al., 2003). This was developed by Semerari's research group, and assesses the understanding of one's own and the other's mind based on qualitative material samples selected from transcriptions of therapy sessions. Decentring, i.e. the awareness of the existence of other perspectives, is one of the assessment dimensions of MAS (Rotola-Pukkila, 2012; Semerari et al., 2003). Rotola-Pukkila (2012) has reported several difficulties related to the application of MAS within process research.

The findings of this research demonstrate, on the level of the dialogue and utterances in the case material, how internal and interpersonal empathy are temporally connected with the ongoing therapeutic process.

4.1.3 The application possibilities of dialogical sequence analysis

Dialogical sequence analysis was used in all three sub-studies as the micro-analytical research method for studying utterances. DSA acted as the method for formulating the problematic interaction pattern of the initial situation, and is was also used for examining on-going interaction, where the focus was on the objects of attention during the conversations and the participants' positioning in relation to these.

The case formulation methods used in psychotherapy process research, originally developed within psychoanalytical psychotherapy for formulating transference phenomena (Eells, 1997, 2007b; Eells & Lombart, 2004; Johnstone & Dallos, 2006; Sturmey, 2009a, 2009b), differ from each other in their focus on the intra-individual–inter-individual axis. Some of these methods, such as the Core Conflictual Relationship Theme (CCRT) method (Luborsky, 1997; Luborsky & Barrett, 2007) and configuration analysis (Horowitz, 1997), focus solely on the intra-psychic level of relationship patterns, internal wishes or internal conflicts. Other approaches, such as Structural Analysis of Social Behaviour (SASB) (Benjamin, 1974), Cyclical Maladaptive Patterns (CMP) (Strupp et al., 1988) and the Plan Formulation Method (Curtis, Silberschatz, Sampson, & Weiss, 1994), in addition to the intra-personal dimension, also take the inter-personal dimension into account, e.g. the relationship between oneself and the other or the relationship between the client and the therapist. Similarly, discourse analysis-based therapeutic process research (e.g. Kurri, 2006) focuses only on interaction phenomena. Doing this involves the creation of considerable definitions and outlining the objects of psychic action. This gives rise to the possibility of leaving clinically significant questions, such as how psychic problems change during psychotherapy discussions and with its help, or how therapeutic discussion promotes psychic change, outside the sphere of observation (Leiman & Stiles, 2001; Stiles et al., 2006). The findings of this research show that DSA, which makes no pre-assumptions regarding the internal or external nature of the positioning conveyed in utterances, enables a flexible analytical approach between the intra-psychic and inter-personal perspectives.

The third sub-study demonstrated how dialogical sequence analysis can also be applied when examining interaction within group situations. Thus far, DSA has been applied in group

situations in the study by Kaunisto, Estola, & Leiman (2013). The third sub-study shows the possibilities of DSA for denoting double positioning. The author is always positioned in relation to the referential object as well as to the addressee. Here, DSA borders on the latest formulations (Voutilainen, Peräkylä, & Ruusuvuori, 2011) of another transcription-based interaction method, conversation analysis (Peräkylä et al., 2008; Peräkylä & Sorjonen, 2012).

In the third sub-study, the DSA-based case formulation identified during the data session was utilised for the methodical triangulation and validation of the accuracy of the formulation used by the cognitive analytic psychotherapy orientated neuropsychologist (Bennett & Parry, 1998; Ryle & Bennett, 1997). The neuropsychologist shared the formulation with the parents at the beginning of the clinical assessment process. It was based on the parent–child relationship that had already manifested during the early stages of the assessment process. The DSA case formulation was constructed by a data session team 1.5 years after Satu's clinical assessment process.

4.3 Conclusions and implications

An important finding relating to clinical work with children and families is that the child neurological assessment is a therapeutic intervention for the parent. The observed change in the parent's perspective was also beneficial for the child: after the assessment period, at the three-month follow-up, the parents had developed child-orientated interaction methods and gained more understanding of the child's perspective as well as their own role in the interaction with the child. The research concluded that the parent's sense of otherness was developed and the parent was able to perceive the child as an individual actor with a will, motives, perspectives and starting points of their own.

The assessment of a child is also in itself an intervention for the parents. Child clinical assessment is a process during which significant changes in the parent's positioning and perspective occur. The findings of this research highlight the process nature of the clinical child assessment and care work. A clinical child neurological assessment has a process nature, just as do the child's and the family's everyday life. The approach of the parent's change does not translate into therapy for the parents, but such methods of work and action applied during the assessment process that reinforce the parent's understanding of the child and the parent's self-understanding through and during activities with the child, as well as the development of the parent's agency. Even the initiation of assessment and going through the process is an important opportunity for a parent who is wrestling with problems related to their child to change their perspective. The challenge lies in how the process nature of examination and assessment, which during economically scarce times in particular are primarily conducted as basic tasks of health care, could be supported in the present outcome and performance objectives.

This research was conducted by a clinician. The preliminary research questions arose from practice-based evidence (Barkham, Hardy, & Mellor-Clark, 2010a; Bower & Gilbody, 2010). The approach of studying the individual outcome, using case formulations and following the progress of the process as qualitative change, can be generalised for broader application within the evaluation of psychological assessment and care processes. The tools utilised for observing process, dialogical sequence analysis and the assimilation model, are applicable for observing different processes and interventions. The evaluation of individual outcomes should be a routine

part of the clinician's report on the assessment and care processes that they have conducted. These evaluations should also be communicated as part of the service system's reflective observation and development (Barkham, Hardy, & Mellor-Clark, 2010b; Bower & Gilbody, 2010). The case formulation method, DSA, has been applied to the study of therapeutic change as well as to consulting and guidance. Other non-therapy contexts where the interaction between adult and child is of significant importance (and could thus also utilise the methods of process research) could be, for instance, day care and education.

The significance of this research can be reflected in relation to clinical work and possible further research, but also from another approach: what has it taught its creator? I have now arrived at the stage which I knew nothing about when I began my investigation (see epigraph on p. 1, Stiles & Brinegar, 2007). The following citation from William B. Stiles (2005a, p. 63) crystallises what I have learned. I started off with a research question that arose from a clinical context. The intensive examination of Satu's case has lead me to the following conclusion:

"Case-studies make the theory building logic of science more explicit. By offering no context-free conclusions, the case study logic makes it harder to maintain an illusion of context-free knowledge."

Knowledge is produced in a specific context (Leiman, 2001b), but its theoretical findings are transferrable (McLeod, 2010). In this case, the intensive study of a single case generated theoretical findings on the phases of developing empathy, which has an impact on the broader understanding of the progress of therapeutic processes.

Case studies are a way for clinicians to conduct research. Cases studies offer the opportunity to capture the complexity, notes and fine-tuning of phenomena, as well as the individual characteristics of the client, patient or case.

Stake (2005) compared the case study researcher to a teacher who has at least two methods at hand: didactic and discovery learning. By describing the chronology of events and by formulating the different aspects of the case, the researcher acts as a didacticist. A case study researcher can also offer the reader discovery-based information on the case. The reader of a case study may identify with the case's actors and thus is offered the possibility of vicarious learning. The researcher, too, learns about the case, but also about themselves and the long research process. Empathy is connected to the understanding of the case in several ways (von Wright, 1971; Stake, 2005, p. 454).

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Appendix 1.

INFORMATION FOR THE RESEARCH CANDIDATE ST/2005/2/16.2.2005

HUCH / Neuropsychologist, Lic.A. (Psych.) Soile Tikkanen, is conducting her PhD dissertation, titled **Concern over development and the formation of the parent's perspective**, at the Child Neurology Unit, Ward L5.

The objective of the research is to describe the parent's perspective on their child's situation, and how the perspective changes in dialogue with the professional assessing the child. The research will provide qualitative information on the content of collaboration in child neurological assessment, which is also important in regard to the development work of child neurological assessment and care practices.

The research is being conducted as part of the standard assessment practices at the child neurology unit/outpatient clinic.

Research candidates have been selected with the following criteria: parents whose 3–4-year-old child has received a referral for child neurological/neuropsychological assessment and no such assessment has previously been made.

Neuropsychologist Soile Tikkanen will personally contact parents who have received a referral in order to provide additional information on the nature of the research and to receive your consent for participating in this scientific research.

To provide material for the research, the conversations between the parents and different professionals (doctor, occupational therapist, speech therapist, physiotherapist, neuropsychologist, social worker) will be video recorded during the course of the child neurological/neuropsychological assessment process as well as at the three-month follow-up. Sessions involving just the child and professional will only be recorded if the parent is also present at the assessment appointment.

The video recordings made for the analysis of research material will be transcribed into written form, in conversation lines. All sections which allow the identity of the parent, child or professional participating in the conversation to be identified will be erased.

The conversation lines transcribed during the reporting phase of the research as well as other research information may be used as samples and descriptions to illustrate the phenomena being researched.

Participation in this research is entirely voluntary, and consent can be withdrawn at any phase of the assessment. Refusal to participate in the research, withdrawing consent that has been given or cancelling participation in the research mid-assessment will not affect the assessment process at the child neurology outpatient clinic or the findings of this assessment in any way.

The participants in the research will be provided with a written summary of the findings of the research once it has been completed. After the completion of the research, the tape material and transcriptions that have been gathered will be stored as part of the psychological assessment records in the patient's medical records in accordance with relevant legislation.

The supervisor of Soile Tikkanen's PhD dissertation is docent Mikael Leiman, University of Joensuu.

Additional information on the research is provided by the researcher, tel. +358 9 861 24 57. The doctor in charge for the assessment is Docent Hannu Heiskala, Chief Physician of Child Neurology, Child Neurology Ward L5, HUCH, Jorvi Hospital, tel. +358 9 861 54 53.

Original publications are not included in the electronic version of this dissertation report.

PUBLICATIONS OF THE UNIVERSITY OF EASTERN FINLAND DISSERTATIONS IN EDUCATION, HUMANITIES, AND THEOLOGY

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